

Claims Filing

Coding

ADA Current Dental Terminology (CDT) Handbook

Dentists typically use the American Dental Association's Current Dental Terminology Fourth Edition (CDT-4) handbook. You can order the most current guide from:

American Dental Association
211 East Chicago Ave.
Chicago, IL 60611

Phone: 1 (312) 440-2500

Oral Surgery Codes That May Process Under HMSA's Medical Plans

I. Procedure Codes

The following oral surgery codes may be processed under the benefits of the patient's HMSA Medical Plan. When submitting a claim for any of these listed services, remarks, treatment notes or pathology reports where indicated, must be attached.

CDT Code	Description
D7260	Oroantral fistula closure
D7285	Biopsy of oral tissue – hard (bone, tooth)
D7286	Biopsy of oral tissue – soft
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7520	Incision and drainage of abscess – extraoral soft tissue
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7910	Suture of recent small wounds up to 5 cm

General Claims Filing Information

COMPLETING A DENTAL CLAIM FORM – ADA 2006

To expedite processing, please complete your claims carefully. Use CDT procedure codes to identify services rendered. Be sure to verify that each code is entered correctly on the claim form; a simple transposition error can delay processing. If a procedure code is missing, the claim will be returned to you.

Completing a dental claim form

The following instructions are designed to assist you in completing the most current *ADA Dental Claim Form*. A copy of the claim form can be found on the ADA website or in the most current ADA Current Dental Terminology. These data elements are grouped according to the claim form design.

Header Information

Block 1: Enter an X in the appropriate box to indicate if this claim is a pre-treatment estimate or a claim for actual services rendered.

Block 2: Predetermination/Preauthorization Number is not required

Insurance Company/Dental Benefit Plan Information

Blocks 3: Carrier name, address, city, state, zip code

Enter the following address:

HMSA Dental
P.O. Box 1187
Elk Grove Village, IL 60009-1187

Other Coverage

Blocks 4-11: This section contains information on the existence of other medical or dental insurance policies that is necessary to determine coordination of benefits.

Policyholder/Subscriber Information

Blocks 12 – 17: This section documents the information about the insured person (subscriber) who may or may not be the patient.

Patient Information

Blocks 18 - 23: This section contains information specific to the patient.

Record of Services Provided

Blocks 24-35: This section contains the information regarding the treatment performed or proposed. Please note: a pre-treatment estimate should be completed the same way as a actual service on the claim form, but omitting the date of service. There are 10 lines available for reporting services on a claim form.

Authorizations

Blocks 36 and 37: This is the signatory area for the patient or subscriber providing consent for treatment as well as authorization for direct payment.

Ancillary Claim/Treatment Information

Blocks 38-47: This section provides additional information regarding the claim and the patient's prior dental history. Some of these questions may be blank if the service being provided is not orthodontic or prosthetic.

Billing Dentist or Dental Entity

Blocks 48-52A: This section provides information on the dentist or group/corporation that is responsible for billing and receiving payment. This may or may not be the treating dentist. **Please note block 49 is specific to reporting the associated NPI.**

Treating Dentist and Treatment Location Information

Blocks 53 – 56A: This section provides information that is specific to the dentist who has provided treatment. **Box 53 requires either a signature or imprinted name of the treating dentist. Box 54 is specific to reporting the treating dentist's NPI.** Visit our website, www.bshi.net/provider additional information on obtaining your NPI.

All claims must be submitted with your NPI.

Billing for Tax

DENTAL CLAIMS FILED ELECTRONICALLY

Dental providers must not report a separate line for tax on claims submitted electronically. For claims with multiple lines of charges, the tax should be calculated for each line based on the line's actual charge and the tax amount should be included in the line charge amount. The tax amount will also be identified for each service line with segment AMT and qualifier T. (Please refer to HIPAA Implementation Guide Addenda for dental claims processing [004010X097A1])

DENTAL CLAIMS SUBMITTED ON PAPER ADA 2006

For paper claim submissions, the tax must be billed using HMSA's code for tax, Z9020 and should be calculated based on sum of the total service lines. The tax should be located below the last service line in the block, Record of Services Provided. Only one tax line is required. The tax line should have the code Z9020 entered in block 29, Procedure Code. The sum of the service lines and the tax line become the Total Charge shown in block 33.

CALCULATING TAX

The amount of tax, whether it is reported on a separate line (for paper claims) or included in the service line amount (for EMC claims), the tax should be calculated based on the actual charge for that service line – not based on HMSA's maximum allowable charge (MAC), the HMO fee for that service or other lesser amount. HMSA's claims processing system will adjust the tax to indicate the correct amount owed by the member when we determine the eligible charge and process the claim.

If you do not bill the tax based on the actual charge, the amount on the Dental Remittance will reflect an incorrect amount.

CDT PROCEDURE CODES REQUIRING ATTACHMENTS

The following CDT procedure codes require attachments with claims submission.

Procedure Code	Dental radiographs are needed for the following procedures:
D2961	labial veneer (resin laminate) - laboratory
D2962	labial veneer (porcelain laminate) - laboratory
D6058 – 6067, 6094	single crowns, abutment/implant supported
D7230	removal of impacted tooth – partial bony
D7240	removal of impacted tooth – completely bony
D7241	removal of impacted tooth – completely bony with unusual surgical complications
Procedure Code	Periodontal charting is required for the following procedures:
D4210, D4211	gingivectomy or gingivoplasty
D4240, D4241	gingival flap procedure including root planing
D4260, D4261	osseous surgery
D4341, D4342	periodontal scaling and root planing
Procedure Code	Remarks, narrative or treatment notes are needed for the following procedures:
D2980	crown repair, by report
D4249	clinical crown lengthening – hard tissue
D4266	guided tissue regeneration – resorbable barrier
D4267	guided tissue regeneration – nonresorbable barrier
D4271	free soft tissue graft

D6980	fixed partial denture repair, by report
D7471	removal of lateral exostosis
D7472 - 7473	removal of torus
D7550	partial ostectomy/sequestrectomy
D9999	unspecified procedure, by report
Procedure Code	Remarks, treatment notes or pathology reports where indicated are required for the following procedures that may be covered by medical plans:
D7260	oroantral fistula closure
D7285 - 7286	biopsy
D7410 - 7412	excision of lesions
D7413 - 7415	excision of malignant lesion
D7440 - 7441	excision of malignant tumor
D7460 - 7461	removal of benign nonodontogenic cyst or tumor
D7520 - 7521	incision and drainage of abscess – extraoral soft tissue
D7910	suture of recent small wounds up to 5 cm

CLAIMS FILING TIPS - DENTAL

To expedite processing, please complete your claims carefully. The following considerations are particularly important:

- We need both the provider's signature (or the signature of an authorized representative) and the correct NPI and TIN to process the claim. If these items are missing, the claim will be returned to you.
- Use CDT procedure codes to identify services rendered. Be sure to verify that each code is entered correctly on the claim form; a simple transposition error can delay processing. If a procedure code is missing, the claim will be returned to you.

REGISTERING YOUR TAX ID AND NPI

HMSA would like to help your office better understand the importance of the relationship between the Type 1 and 2 National Provider Identifier (NPI), Employer Identification Number (EIN), and your Business Classification when filing your HMSA claims. We will explain the importance of correctly registering these numbers with HMSA to ensure that your claims are correctly adjudicated with the appropriate fee schedule and ensure payment is sent to the correct office location.

Definitions:

NPI numbers are issued by the National Plan and Provider Enumeration System, or NPPES. You may apply for, or verify your NPI number, by going to their website:

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

The Type 1 NPI number is used to identify the **treating provider**. The Type 2 NPI number is used to identify the billing entity. Sub-part NPIs can be obtained through the NPPES for additional locations of business organizations run under the same Tax Identification Number (TIN).

The **billing entity** is defined as a business organization or business classification: Limited Liability Corporation (LLC), Corporation (Inc.), or Partnership. It is very important to understand and know how your business is organized and classified to correctly apply for your business NPI.

The Tax Identification Number (TIN) is the number on file with the IRS for 1099 reporting. EIN is often confused with the TIN. They are not synonymous. A TIN is either an EIN or a Social Security Number (SSN).

Importance of accurate claims filing:

The grid below outlines where to enter each of these identifiers, depending on your Business Classification, on the ADA 2006 claim form.

Business Classification	Billing Provider’s NPI [Box 49]	Billing Tax ID [Box 51]	Treating Provider’s NPI [Box 54]
Individual	Type 1 NPI	SSN	Type 1 NPI
Individual with multiple locations	Type 1 NPI	SSN	Type 1 NPI
Sole Proprietor*	Type 1 NPI	EIN	Type 1 NPI
Sole Proprietor * with multiple locations	Type 1 NPI	EIN	Type 1 NPI
Limited Liability Company (LLC) – individual dentist*	Type 1 NPI	SSN	Type 1 NPI
Limited Liability Company (LLC) – multiple dentist	Type 2 NPI	EIN	Type 1 NPI
Incorporation/Partnership	Type 2 NPI	EIN	Type 1 NPI

*A Sole Proprietor business classification cannot support multiple employees/independent contractors paying to one billing entity.

PROMPT CLAIMS FILING

It is important to file your claims on a timely basis. HMSA dental plans have a one-year claims filing limitation. Claims that are not filed within one year of the date of service are not payable.

Coordination of Benefits - Dental

HMSA AND ANOTHER EMPLOYER-SPONSORED GROUP PLAN OR TWO HMSA PLANS

Coordination of benefits (COB) is employed when a member has dental coverage from more than one source. Using the order of benefit determination guidelines recommended by the National Association of Insurance Commissioners (NAIC), HMSA determines the primary and secondary plans and coordinates benefit payments between the plans.

The following guidelines apply when a patient has more than one dental plan:

- The plan that covers the patient as the subscriber or policyholder pays first.
- If a child is covered under both the mother's and father's plan, the plan of the parent whose birthday is earlier in the calendar year pays first. (If both parents have the same birthday, the plan with the earlier effective date pays first.)
- If a member is the subscriber of more than one plan, the plan with the earlier effective date is primary.
- Benefits of both plans will coordinate to a maximum of 100 percent of HMSA's eligible charge.
- **Note:** Coverage of dependent children of divorced or separated parents is determined according to special rules. Please call a Provider Services Dental Servicing Representative if you have questions about these coverage rules.

CLAIMS FILING INSTRUCTIONS FOR DUAL COVERAGE

When a patient is covered by HMSA and another plan, it is important to provide additional information about the second plan to ensure that full benefits are provided.

If you believe HMSA will be the primary payer according to the guidelines above, please file the claim promptly after services are completed. If you think HMSA is the secondary payer, please send the claim to the primary payer first.

For a patient with HMSA plus another dental plan, please mark "yes" in Block 4 of the American Dental Association claim form and include the patient's other policy number in Block 8, along with the required information for Blocks 5-11 (other insurance carrier, secondary insurance carrier, date of birth) and 12-23.

Other Liable Parties

Injury/Illness Report Form

Under the provisions of HMSA plans, medical claims for which another party may be responsible, such as an accident, are not payable by HMSA. Under certain circumstances, however, claims submitted to the responsible party's insurance carrier and subsequently denied

may be considered by HMSA for payment after an **Injury/Illness Report Form** is completed and signed by the member. The completed form should be faxed to HMSA Other Party Liability at 952-7987. For details, see Workers' Compensation

Workers' Compensation

Under the provisions of HMSA plans, medical claims for which workers' compensation coverage may be available are not covered. These provisions apply to claims for services provided in connection with an injury or illness that may be work related.

Claims for a work-related injury or illness must be submitted to the patient's employer's workers' compensation carrier. If HMSA pays benefits for services that should have been billed to workers' compensation, HMSA will seek reimbursement from the participating provider.

65C Plus follows the same (Medicare Secondary Payer) MSP guidelines as Medicare for workers' compensation cases.

Payment Denial by Workers' Compensation Carrier

If the workers' compensation carrier denies payment, either the patient or the provider may notify HMSA of the denial. We will then send the non-QUEST member an **Injury/Illness Report Form** and ask that the form be completed and returned to us, along with a copy of the denial letter from the workers' compensation carrier.

Although the form is sent by HMSA to the member when an investigation is opened, members sometimes forget to return the completed form in a timely manner. A provider may assist HMSA with its information gathering by copying the form and asking the member to complete the form in his or her office. The provider may then return the unaltered, signed and completed form to HMSA to facilitate the investigation. The form should be sent to:

Other Party Liability Unit, 8th floor
HMSA - Claims Administration Department
P.O. Box 860
Honolulu, HI 96808-0860

Claims Payment

Upon receipt of the required documents and confirmation that workers' compensation benefits are not available, HMSA will process claims related to the injury or illness in accordance with the benefits of the member's plan.

Notes:

All claims paid by HMSA are subject to member eligibility at the time of service, HMSA's

guidelines for payment determination, and the provisions and limitations of the member's plan.

If the member does not provide the information requested by HMSA in connection with the injury or illness, claims for related services may be delayed or denied.

Member Questions

Members with questions regarding HMSA's third party rules should refer to their HMSA Guide to Benefits (GTB). Members may request a copy of their GTB or other assistance from HMSA's Customer Service Department at:

HMSA Dental Services
P.O. Box 1320
Honolulu, HI 96807-1320

Third Party Liability

Third party liability is when the patient has been injured or becomes ill, **and:**
The injury or illness is caused, or alleged to have been caused, by someone else, and
The patient has or may have the right to recover damages or receive payment in connection with the injury or illness, or
The patient has or may have the right to recover damages or receive payment without regard to fault.

Examples of situations for which a third party may be financially responsible for a member's injury or illness:

- The patient was bitten by a neighbor's dog.
- The patient fell on the front steps of a friend's house.
- The patient fell in a department store.
- The patient was assaulted by a third party.

For HMSA to determine its liability for coverage and protect its rights to recover payments in the event of a settlement, the member's cooperation is essential. HMSA will provide benefits in connection with the injury or illness, in accordance with the member's plan benefits, if the member assists HMSA by providing the information indicated below. The member must:

Give HMSA timely notice in writing no later than 30 days after the occurrence of each of the events listed below:

His or her knowledge of any potential claim against any third party or other source of recovery in connection with the injury or illness

His or her knowledge of any written claim or demand (including legal proceedings) against any third party or other source of recovery in connection with the injury or illness

Any recovery of damages (e.g., settlements, judgments, awards or insurance proceeds) against any third

party or other source of recovery in connection with the injury or illness

Sign requested documents. The member must sign and deliver to HMSA the documents (e.g., liens, assignments) HMSA deems necessary to secure its rights to recover payments. The member also must direct any person receiving payment on his or her behalf to reimburse HMSA for claims paid to the member's healthcare providers for services related to the injury or illness.

Provide information. The member must provide HMSA with any and all information required to investigate its liability for coverage and to determine its rights to recover payments. The primary source of this information is HMSA's **Injury/Illness Report Form**.

Although the Injury Illness Report Form is sent by HMSA to the member when an investigation is opened, members sometimes forget to return the completed form in a timely manner. A provider may assist HMSA with its information gathering by copying the form and asking the member to complete the form in his or her office. The provider may then return the unaltered, signed and completed form to HMSA to facilitate the investigation. The form should be sent to:

Other Party Liability Unit, 8th floor
HMSA - Claims Administration Department
P.O. Box 860
Honolulu, HI 96808-0860

Once the required documents are received and the HMSA member record has been updated, HMSA will process remaining claims in accordance with the benefits of the member's plan.

Notes: All claims paid by HMSA are subject to member eligibility at the time of service, HMSA's guidelines for payment determination, and the provisions and limitations of the member's plan.

If member does not provide the information requested by HMSA in connection with the injury or illness, claims for related services may be delayed or denied.

Member Questions

Members having questions regarding HMSA's third party rules should refer to their Guide to Benefits (GTB). Members may request a copy of their GTB or other assistance from HMSA's Customer Service Department at:

HMSA Dental Services
P.O. Box 1320
Honolulu, HI 96807-1320

Motor Vehicle Insurance

Under the provisions of HMSA plans, medical claims for which motor vehicle insurance benefits are available are not payable by HMSA. These provisions apply to claims for services furnished

in connection with an injury or illness caused by the use, maintenance or operation of a motor vehicle. Claims for such services must be submitted to the motor vehicle insurance carrier in accordance with Hawaii state law and regardless of fault.

Examples of situations covered by motor vehicle insurance:

- Injury caused by an automobile accident
- Injury caused while opening or closing an automobile door
- Injury caused while loading or unloading passengers or groceries from an automobile
- Injury caused when children are playing in an unattended automobile
- Injury caused by a hit-and-run automobile accident
- Injury to a pedestrian involving an automobile
- Injury to a bicyclist or moped driver involving an automobile
- Injury caused to a person pushing an automobile

If your patient is involved in a motor vehicle-related accident, please submit claims to the motor vehicle insurance carrier first. If HMSA pays benefits for services that should have been billed to a motor vehicle insurance carrier, HMSA will seek reimbursement from the participating provider.

When the patient exhausts his or her personal injury protection benefits, HMSA will need the following information before any remaining claims relating to the accident can be processed:

A letter from the motor vehicle insurance carrier indicating that personal injury protection benefits are exhausted

A detailed list from the motor vehicle insurance carrier, indicating which claims were covered by the motor vehicle insurance carrier. The list must show the date expenses were incurred, the provider of service and the amount paid by motor vehicle insurance.

A completed **Injury/Illness Report Form** signed by the injured member. Although the form is sent by HMSA to the member when an investigation is opened, members sometimes forget to return the completed form in a timely manner. A provider may assist HMSA with its information gathering by copying the form and asking the member to complete the form in his or her office. The provider may then return the unaltered, signed and completed form to HMSA to facilitate the investigation. The form should be sent to:

Other Party Liability Unit, 8th floor
HMSA - Claims Administration Department
P.O. Box 860
Honolulu, HI 96808-0860

Once these items are received and the HMSA member record has been updated, HMSA will process remaining claims in accordance with the benefits of the member's plan.

Note: The member is responsible for any cost-sharing payments required by his or her motor vehicle insurance policy. HMSA will not cover personal injury protection cost-sharing

payments.

All claims paid by HMSA are subject to member eligibility at the time of service, HMSA's guidelines for payment determination, and the provisions and limitations of the member's plan.

If the member does not provide the information requested by HMSA in connection with the injury or illness, claims for related services may be delayed or denied.

Member Questions

Members with questions regarding HMSA's third party rules should refer to their HMSA Guide to Benefits (GTB). Members may request a copy of their GTB or other information from HMSA's Customer Service Department at:

HMSA Dental Services
P.O. Box 1320
Honolulu, HI 96807-1320

HMSA



INJURY/ILLNESS REPORT FORM

SECTION I: GENERAL INFORMATION PLEASE COMPLETE THIS SECTION

- a) Name of HMSA member or dependent injured or ill: _____
- b) Date of injury/illness: _____
- c) Where did this occur? Work Home
 Other (please explain) _____
- d) Please describe how your accident happened: _____
- e) Diagnosis or brief description of the type of injury/illness (example: broken ankle)

- f) Your phone number: _____ Work _____ Home _____
- g) Have you hired or plan to hire an attorney to represent you in connection with this injury or illness?
 Yes No. If "YES," please indicate:
Name of your attorney: _____
Address: _____ Phone: _____

SECTION II: WAS YOUR ACCIDENT RELATED TO YOUR WORK? YES NO PLEASE COMPLETE THIS SECTION IF YOU ANSWERED "YES" ABOVE

- a) Have you filed for Workers' Compensation? Yes No
If "NO," please explain: _____
If "YES," please answer the following questions.
- b) What is the status of your Workers' Compensation claim? _____
- c) Who is your employer? _____ Phone: _____
What insurance company covers your Workers' Compensation?

Note: If your case has been settled, please submit a copy of the settlement document.

SECTION III: DID YOUR INJURY INVOLVE A MOTOR VEHICLE? YES NO PLEASE COMPLETE THIS SECTION IF YOU ANSWERED "YES" ABOVE

- a) Please check one: Were you a passenger? driver? pedestrian?
- b) If you were a **passenger** or a **driver**, please indicate:
The owner of the vehicle: _____
Address: _____ Phone: _____
The name of the company which insured the vehicle you were in: _____
- c) If you were a **pedestrian**, please indicate:
The name of the owner of the vehicle which struck you: _____
Address: _____ Phone: _____
The name of the insurance company which insured that vehicle: _____
- d) Are no-fault benefits available for this accident? Yes. No.
If "YES," please indicate your policy limit: \$_____
If "NO", please explain: _____

(continued on next page)

INJURY/ILLNESS REPORT FORM

PAGE TWO

- e) The name of your motor vehicle insurance carrier: _____
If none, the name of the motor vehicle insurance carrier of anyone in your household?

SECTION IV: DO YOU BELIEVE ANOTHER PERSON(S) IS OR MAY BE RESPONSIBLE FOR YOUR ACCIDENT OR ILLNESS? YES NO PLEASE COMPLETE THIS SECTION IF YOU ANSWERED "YES" ABOVE

- a) Name and address of person(s) you believe could be responsible:
Name: _____
Address: _____
- b) Date on which you discovered that the person(s) could be responsible: _____
- c) Have you made any written claim or demand, or initiated any legal action, against that person(s) in connection with your accident or illness? Yes. No.
If "NO," please explain: _____
If "YES," please answer the following questions.
- d) What is the status of your claim, demand, and/or action? _____
Please send us a copy of all claims, demands, and/or complaints that you have made or that have been made on your behalf, regarding your accident or illness.
- e) Have you received any money from another source as a result of your accident?
 Yes. No.
If "YES," please give us the name of the source: _____
- f) If there was a settlement, what was the date of the settlement? _____
What was the settlement amount? _____
What is the name of the person or carrier from which you received this money?

Please send us a copy of your settlement document.
- g) If you will not be pursuing any third party claim against the other party who may be at fault, please explain why: _____

PLEASE READ THE FOLLOWING CAREFULLY

By signing below, I certify that the above information is true and correct to the best of my knowledge and that I have received a copy of HMSA's Third Party Liability and Motor Vehicle Insurance Rules.

Name of Member or Dependent
(PLEASE PRINT)

Signature of Member or Dependent

HMSA Membership Number

Date

Any alterations or changes you make to this Agreement will render the Agreement void and invalid.

Procedures for Filing Orthodontic Claims

FILING ORTHODONTIC CLAIMS - ELECTRONIC

- Submit one line with the banding fee code (D8080-D8090) and the charge for the banding.
- Submit one line with the monthly adjustment code (D8670). This line should reflect the difference between the total charge and the initial deposit amount.

The total months of treatment should be filed in the DN1 segment of Loop 2300. (Providers should verify with their practice management vendor that the data is being captured and written to the DN1 segment of the 837 files they produce.)

Filing a claim for transfer case

- Submit one line with the monthly adjustment code (D8670), the **total months** of treatment **remaining**, and the **total charge** for the **remaining** monthly adjustments. In this case, the total months of treatment **remaining** should be filed in the DN1 segment of Loop 2300.

NOTE: We will calculate the monthly charge by dividing the total charge for the remaining monthly adjustments by the total months of treatment remaining.

FILING ORTHODONTIC CLAIMS - PAPER

- Submit one line with the banding fee code (D8080-D8090) and the charge for the banding.
- Submit one line with the monthly adjustment code (D8670). This line should reflect the difference between the total charge and the initial deposit amount.

The total months of treatment should be listed in box 42 of the 2006 ADA Claim Form.

Filing a claim for transfer case

- Submit one line with the monthly adjustment code (D8670), the **total months** of treatment **remaining**, and the **total charge** for the **remaining** monthly adjustments.

The total remaining months of treatment should be listed in box 42 of the 2006 ADA Claim Form.

NOTE: We will calculate the monthly charge by dividing the total charge for the remaining monthly adjustments by the total months of treatment remaining.

When you file one of the claims above, you do not need to file any more orthodontic claims to us for the patient. In either instance, we will automatically send you payment for the monthly adjustments on or around the first day of each month until:

- The patient exhausts his lifetime orthodontic benefits, or
- The patient's dental coverage terminates under his current policy, or
- The patient reaches the maximum age allowed for orthodontic coverage under his current policy.

When one of the above occurs, we will notify you via your remittance and stop our automatic claim spin off process.

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
 Statement of Actual Services Request for Predetermination/Preauthorization
 EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
HMSA DENTAL
PO BOX 1187
ELK GROVE VILLAGE, IL 60009-1187

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscriber ID (SSN or ID#)
 M F

9. Plan/Group Number 10. Patient's Relationship to Person Named in #5
 Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named In #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
MR. JOHN MEMBER
1400 KAPIOLANI BLVD
HONOLULU, HI. 96813

13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscriber ID (SSN or ID#)
01/01/1971 M F R000012345678

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above 19. Student Status
 Self Spouse Dependent Child Other FTS PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)
 M F

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	10/01/10					D8090	COMPREHENSIVE ORTHO TX-ADULT	1500.00
2						D8670	PERIODIC ORTHODONTIC VISIT	3500.00
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)	Permanent																Primary												32. Other Fee(s)	33. Total Fee
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J				
																	T	S	R	Q	P	O	N	M	L	K		5000.00		

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 39. Number of Enclosures (00 to 99)
 Provider's Office Hospital ECF Other Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? 41. Date Appliance Placed (MM/DD/CCYY)
 No (Skip 41-42) Yes (Complete 41-42) 10/01/10

42. Months of Treatment Remaining 43. Replacement of Prosthesis? 44. Date Prior Placement (MM/DD/CCYY)
24 No Yes (Complete 44)

45. Treatment Resulting from
 Occupational illness/injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
HMSA DENTAL
PO BOX 1320
HONOLULU, HI. 96807

49. NPI 50. License Number 51. SSN or TIN
HI 1320

52. Phone Number () - 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI 55. License Number

56. Address, City, State, Zip Code 56A. Provider Specialty Code

57. Phone Number () - 58. Additional Provider ID